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A Brief Overview of Transgender Identity: Historical and Mental Health Perspectives

Carol D. Denniston, PhD
Dallas Denny, M.A.

Transgender is a term used to describe individuals who have persistent and significant discomfort with their assigned gender (White & Townsend, 1998). Transgender individuals were born biologically male or female, but live their lives to varying degrees as the opposite gender. Gender identity refers to an individual's self-identification as male, female, or other. Male and female are extremes on the gender continuum and many transgender people identify as somewhere in the middle, or gender variant. A transexual is a transgender individual who seeks genital reassignment surgery. Not all transgender individuals are seeking to "transition" through hormone therapy, aesthetic surgery, or genital surgery; in fact, many do not. Transgender people are referred to as male-to-female (MTF) or female-to-male (FTM).

It is also important to distinguish between gender identity and sexual orientation. It is a myth that all MTF transgender individuals are attracted to men, or that they are really homosexuals. Many MTFs are happily married and have no desire to leave their wives. MTFs and FTMs may be attracted to men, women, or both and may identify as homosexual, bisexual, or heterosexual. It is important not to confuse these issues.

Dallas Denny, M.A.

Variant expressions of gender—what we today call transgender and transsexualism—have been present throughout human history (Taylor, 1996). Gender roles outside the binary male/female were recognized members of a variety of tribal cultures (Herdt, 1994), but until recently have been repressed in Western societies (Bullough & Bullough, 1993). Historical documents suggest that many women lived socially as men (Dekker & van de Pol, 1989; Hall, 1996) from the Middle Ages on. Legal documents showing that men lived as women are less common, but this may be artifactual, due at least partly to the fact that until recently women were largely excluded from activities which would have generated legal documents. Nonetheless, there are many reports of men who lived as women (Bullough & Bullough, 1993).

Carol D. Denniston, PhD
Licensed Clinical Psychologist
Wash. Psychological Center, PC

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Gender-variant expression came to the attention of the early sexologists Hirschfeld (1910, 1991) and Ellis (1906), who differentiated it from homosexuality. As the twentieth century progressed, gender variance became increasingly medicalized, especially after Christine Jorgensen's sex reassignment in Denmark (Hamburger et al., 1953). Following Jorgensen's sex reassignment, increasing numbers of men and women began demanding similar treatment (Hamburger, 1953). This eventually resulted in the formation of the first U.S. gender clinic at Johns Hopkins University (Money & Schwartz, 1969). A textbook by Benjamin (1966) defined the syndrome of transsexualism and another by Green & Money (1969) described Johns Hopkins' interdisciplinary approach to sex reassignment.

The psychomedical literature of the second half of the 1950's treated transsexualism and crossdressing as forms of mental illness. In 1980, transsexualism found its way into the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association, and remains in the current DSM-IVTR as "Gender Identity Disorder." Crossdressing is present in DSM-IVTR as "Transvestic Fetishism."

In the early 1990s, the term "transgender" arose as an umbrella to describe all sorts of gender-variant people, including crossdressers and transsexuals, and a category which had previously been ignored, transgenderists—those who choose to live as members of the other sex with no desire for genital surgery and sometimes with no hormonal therapy or other body modifications (see Bolin, 1994, for an anthropological perspective on the social change within the transgender community). The newly formed transgender community looked at gender variance not as mental illness, but as an inevitable and important social role toward which some human beings were predisposed. Cross-cultural support to support this interpretation was becoming available (Dragoin, 1997; Herdt, 1994; Roscoe, 1990; Williams, 1986).

This transgender paradigm shift has had a significant impact on the mental health community. However, many would say it has not had enough of an impact. Some mental health professionals continue to pathologize transgender people and lack the understanding and training to effectively provide mental health services to transgender individuals (Cole, Denny, Eyler, & Samons, 2000). Clinical work with transgender individuals requires an understanding and sensitivity to a broad range of transgender experiences as well as various transgender resources. The transgender community has pointed out that few people are entirely comfortable within rigid bipolar gender norms (Boswell, 1991, 1998), and that most people violate these norms to a greater or lesser degree in terms of their sexual orientation, manner of dress, choice of occupation, hobbies, gestures, and speech patterns (Wilchins, 1997).

Today a large community exists, consisting of crossdressers, transsexuals, and transgenderists, most of whom are from the middle and upper classes,

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Transgender Resources

FTM International, Inc.
1360 Mission St., Suite 200
San Francisco, CA 94103
415/553-5987 Voice Mail
TSTGMen@aol.com e-mail
www.ftm-intl.org URL

Gender Education & Advocacy, Inc.
P.O. Box 65
Kensington, MD 20895
301/949-3822 Voice Mail
info@gender.org e-mail
www.gender.org URL

International Foundation for Gender Education, Inc.
P.O. Box 540229
Waltham, MA 02254-0229
781/899-2212 Voice Mail
info@ifge.org e-mail
www.ifge.org URL

National Transgender Advocacy Coalition, Inc.
P.O. Box 123
Free Union, VA 22940
info@ntac.org e-mail
www.ntac.org URL

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and most of whom are Caucasian. There is a second and largely underground group of transgendered people with incomes below the poverty level. This group does not enjoy the same access to health care as the first, and faces a variety of health risks, including HIV.

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In all but a few U.S. municipalities, transgender and transsexual people face employment discrimination (see Currah & Minter, 2000, for a list of cities and states with nondiscrimination laws). They are often rejected by their families, and are at high risk for attack on the street simply because of the way they look (Wilchins, et al. 1997). A study of transgender individuals in the U.S. indicated that approximately 60% had experienced some form of harassment or violence and that 37% had experienced some form of economic discrimination (Lombardi, Wilchins, Priesing & Malouf, in press). Inability to find a job can force them to turn to sex work; inability to procure legal hormones can lead to sharing needles; and, among MTF's, a desire to achieve instant curves via silicone can lead to injection by backroom "practitioners" (Tobin, 2001).

All these activities subject them to risk of HIV infection. This risk has translated into high rates of actual infections. Studies of MTF sex workers in the U.S. report prevalence rates ranging from 20% up to 68% (Clements-Nolle, Marx, Guzman, & Katz, 2001). Fortunately, data are accumulating that document the aforementioned risks and rates of infections; unfortunately, little has been done to reduce risks.

It is difficult to assess accurately the impact HIV has had on the transgender community. Transgenders are rendered invisible by the CDC's policy of classifying them under the MSM (Men who have Sex with Men) category. Additionally, there are very few studies on rates of HIV infection among transgender individuals who do not work in the sex industry. Finally, there is very little in the way of research addressing HIV and FTM individuals. ■

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HIV/AIDS in Transgender Populations...

at risk populations have repeatedly demonstrated that a clear understanding of the cultural complexities of a given population is a key factor in developing effective, targeted HIV education and prevention materials. A recent policy statement by the American Public Health Association (APHA) urges recognition of both MTF and FTM transgendered people as separate and distinct from gay men and lesbians with regard to both research and their health care (APHA, 1999). In June 2001, the CDC released a Program Announcement focusing on Young Men of Color Who Have Sex with Men, which specifically mentions transgendered people by name—a CDC first.

Transgender Populations and HIV Risk

The lack of understanding of transgendered people is due, in part, to their underground status, which has, until recently, contributed to the lack of research. The 'invisibility' of transgendered people in this country becomes easily understood in light of their intense, pervasive stigmatization, since they are largely viewed as the cultural gendered stereotypes of gay men and lesbians (Xavier, 1999). Since disclosure of transgender status results

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Clinical Issues...

The Issue of Competency

True stories abound among transgender individuals of healthcare services that either did no discernible good or, worse, caused significant harm. One of the most common complaints about mental healthcare professionals is that those transgender individuals seeking services are tired of having to educate their therapists in order to receive anything close to competent services. There is a great unmet need for transgender mental health services, but too often clinicians rush in to fill that need without proper preparation. Clinicians must ensure that they receive the necessary education and training that will make them both sensitive to the phenomenological experiences of their clients and knowledgeable about effective assessment and treatment approaches.

To date, psychologists wishing to provide these services have no comprehensive set of guidelines to direct their efforts. The HBIGDA SOC address some of the need for competency of health care professionals providing services to transgender individuals. However, the treatment of competency in the SOC takes a necessarily broad-brush approach because of the multidisciplinary application of the SOC. While they do state that mental health clinicians need to be knowledgeable, they do not address the need for sensitivity. Other authors have proposed more detailed guidelines to address sensitivity and competence of mental health providers (see Israel and Tarver, 1997, and Lombardi, 2001), but none of them carries the authority of a professional association.

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